UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

CYTOGAM (cytomeglavirus immune globulin)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX WRITTEN REQUESTS TO 855-828-4992

CRITERIA:

- For prophylaxis of cytomeglovirus
- **DOCUMENTED** transplantation of kidney, lung, liver, pancreas or heart

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Updated letter of medical necessity

02/06/2014

https://medicaid.utah.gov/pharmacy/